despite ongoing violence and civil unrest.

In recent years, the Chinese Government has demonstrated great efficiency in monitoring the Internet and restricting Web sites such as Facebook, My Space, Twitter, YouTube, blogs, and other outlets of information to monitor the free exchange of ideas among its people and the press.

It has also used advanced technology to jam international satellite and radio broadcasting including the U.S.-funded Voice of America and Radio Free Asia.

In Xinjiang specifically, it has shut down more than 50 Uighur language Internet forums, jammed Radio Free Asia's Uighur-language service, and cut off Internet and mobile phone access in the past week.

In fact, Li Zhi, a top Communist Party official in Urumqi, the capital of Xinjiang, Province, confirmed yesterday that the government cut off Internet access to the region.

Because of such limitations, the Han population now believes that the Uighurs are solely responsible for ongoing unrest, and such misperceptions have elevated the level of ethnic tension. By creating a vacuum of information in and out of Xinjiang, the Chinese Government has exacerbated the crisis.

While the casualty numbers remain uncertain, it is clear that recent developments have incurred an immeasurable human toll, including—but not limited to—the loss of innocent lives.

There have been pictures of children in hospitals, who have been forced to witness violence perpetrated against their parents. The Washington Post today reported emotional stories of women demanding the return of their missing husbands.

And the UK's Guardian reveals an image of an elderly woman on crutches standing defiantly in front of a police riot bus, an image which is eerily reminiscent of the bravery and defiance demonstrated 20 years ago in Tiananmen.

These glimpses of ongoing developments stir great empathy and anger, and it is essential that the whole story be told, among the international community and also within China. This is why I call on the Chinese Government to provide unimpeded press coverage and Internet access, allow journalists to report without restrictions. I condemn the continued repression of Uighurs and violence perpetrated against all innocent civilians in China and hope the ongoing unrest will soon be brought to an end.

BRITISH HEALTH CARE

Mr. KYL. Mr. President, a July 7, 2009, Wall Street Journal editorial ''Of NICE and Men'' describes the denial and delay of health care in Britain as a result of decisions by the British government's health care cost-containment board, the National Institute for Health and Clinical Excellence, NICE.

The article quotes the Guardian, which in 1998 reported, ''Health ministers are setting up [NICE], designed to ensure that every treatment, operation, or medicine used is the proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere.''

Yet NICE routinely denies patients the very treatments and medications they need.

For example, according to the editorial, ''NICE ruled against the use of two drugs, Lapatinib and Sutent, that prolong the life of those with certain forms of breast and stomach cancer.''

Explaining the ruling against the use of a drug that would help terminally ill kidney-cancer patients, Peter Littlejohns, NICE's clinical public health director, said there is ''a limited pot of money.''

The editorial provides numerous other examples of drugs and treatments that are either denied or restricted in order to reduce costs.

And it explains how NICE has even assigned a mathematical formula for determining the maximum amount the government will spend to extend a life for 6 months.

President Obama has praised countries that spend less than the U.S. on health care, while saying we can spend less here too, even while adding tens of millions to a government-run health care program and improving the quality of care.

This editorial clearly and concisely outlines why this cannot be achieved and why, if President Obama's health care plan passes, the administration's new Council for Comparative Effectiveness Research could eventually gain the same authority to deny or delay treatments and care as Britain's NICE.

I ask unanimous consent that this article be printed in the RECORD, and urge my colleagues to consider the facts and arguments contained in this editorial.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, July 7, 2009]

OF NICE AND MEN

Speaking to the American Medical Association last month, President Obama waxed enthusiastic about countries that ''spend less'' than the U.S. on health care. He's right that many countries do, but what he doesn't want to explain is how they ration care to do it.

Take the United Kingdom, which is often praised for spending as little as half as much per capita on health care as the U.S. Credit for this cost containment goes in large part to the National Institute for Health and Clinical Excellence, or NICE. Americans should understand how NICE works because under ObamaCare it will eventually be coming to a hospital near you.

* * *

The British officials who established NICE in the late 1990s pitched it as a body that would ensure that the government-run National Health System used ''best practices'' in medicine. As the Guardian reported in 1998: ''Health ministers are setting up [NICE], designed to ensure that every treatment, operation, or medicine used is the proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere.''

What NICE has become in practice is a rationing board. As health costs have exploded in Britain as in most developed countries, NICE has become the heavy that reduces spending by limiting the treatments that 61 million citizens are allowed to receive through the NHS. For example:

In March, NICE ruled against the use of two drugs, Lapatinib and Sutent, that prolong the life of those with certain forms of breast and stomach cancer. This followed on a 2008 ruling against drugs—including Sutent, which costs about $50,000—that would help terminally ill kidney-cancer patients. After last year's ruling, Peter Littlejohns, NICE's clinical and public health director, noted that ''there is a limited pot of money,'' that the drugs were of ''marginal benefit at quite often an extreme cost,'' and the money might be better spent elsewhere.

In 2007, the board restricted access to two drugs for macular degeneration, a cause of blindness. The drug Macugen was blocked outright. The other, Lucentis, was limited to a particular category of individuals with the disease, restricting it to about one in five sufferers. Even then, the drug was only approved for use in one eye, meaning those lucky enough to get it would still go blind in the other. As Andrew Dillon, the chief executive of NICE, explained at the time: ''When treatments are very expensive, we have to use them where they give the most benefit to patients.''

NICE has limited the use of Alzheimer's drugs, including Aricept, for patients in the early stages of the disease. Doctors in the U.K. argued vociferously that the most effective way to slow the progress of the disease is to give drugs at the first sign of dementia. NICE ruled the drugs were not ''cost effective'' in early stages.

Other NICE rulings include the rejection of Kineret, a drug for rheumatoid arthritis; Avonex, which reduces the relapse rate in patients with multiple sclerosis; and lenalidomide, which fights multiple myeloma. Private U.S. insurers often cover all, or at least portions, of the cost of many of these NICE-denied drugs.

NICE has also produced guidance that restrains certain surgical operations and treatments. NICE has restrictions on fertility treatments, as well as on procedures for back pain, including surgeries and steroid injections. The U.K. has recently been absorbed by the cases of several young women who developed cervical cancer after being denied pap smears by a related health authority, the Cervical Screening Programme, which in order to reduce government healthcare spending has refused the screens to women under age 25.

We could go on. NICE is the target of frequent protests and lawsuits, and at times under political pressure has reversed or watered-down its rulings. But it has by now established the principle that the only way to control health-care costs is for this panel of medical high priests to dictate limits on certain kinds of care to certain classes of patients.

The NICE board even has a mathematical formula for doing so, based on a ''quality adjusted life year.'' While the guidelines are complex, NICE currently holds that, except in unusual cases, Britain cannot afford to spend more than about $22,000 to extend a life by six months. Why $22,000? It seems to be arbitrary, calculated mainly based on how much the government wants to spend on health care. That figure has remained fairly constant since NICE was established and doesn't adjust for either overall or medical inflation.

Proponents argue that such cost-benefit analysis has to figure into health-care decisions, and that any medical system rations care in some way. And it is true that U.S. private insurers also deny reimbursement for some kinds of care. The core issue is whether those decisions are going to be dictated by the brute force of politics (NICE) or by prices (a private insurance system).

The last six months of life are a particularly difficult moral issue because that is when most health-care spending occurs. But who would you rather have making decisions about whether a treatment is worth the price—the combination of you, your doctor and a private insurer, or a government board that cuts everyone off at $22,000?

One virtue of a private system is that competition allows choice and experimentation. To take an example from one of our recent editorials, Medicare today refuses to reimburse for the new, less invasive preventive treatment known as a virtual colonoscopy, but such private insurers as Cigna and United Healthcare do. As clinical evidence accumulates on the virtual colonoscopy, doctors and insurers will be able to adjust their practices accordingly. NICE merely issues orders, and patients have little recourse.

This has medical consequences. The Concord study published in 2008 showed that cancer survival rates in Britain are among the worst in Europe. Five-year survival rates among U.S. cancer patients are also significantly higher than in Europe: 84% vs. 73% for breast cancer, 92% vs. 57% for prostate cancer. While there is more than one reason for this difference, surely one is medical innovation and the greater U.S. willingness to reimburse for it.

* * *

The NICE precedent also undercuts the Obama Administration's argument that vast health savings can be gleaned simply by automating health records or squeezing out ''waste.'' Britain has tried all of that but ultimately has concluded that it can only rein in costs by limiting care. The logic of a health-care system dominated by government is that it always ends up with some version of a NICE board that makes these life-or-death treatment decisions. The Administration's new Council for Comparative Effectiveness Research currently lacks the authority of NICE. But over time, if the Obama plan passes and taxpayer costs inevitably soar, it could quickly gain it.

Mr. Obama and Democrats claim they can expand subsidies for tens of millions of Americans, while saving money and improving the quality of care. It can't possibly be done. The inevitable result of their plan will be some version of a NICE board that will tell millions of Americans that they are too young, or too old, or too sick to be worth paying to care for.

CRISIS IN HONDURAS

Mr. LEAHY. Mr. President, I want to speak briefly about the current political crisis in Honduras. Vermont and Honduras have had a long, close relationship through the Partners of the Americas, and many Vermonters regularly travel to Honduras to engage in health care and other humanitarian and development work in rural communities.

Last week a lawfully elected President—Manuel Zelaya—was forcibly removed from office and flown to a neighboring country by the Honduran military. The military and the Supreme Court apparently believed that President Zelaya was acting in a manner that was contrary to the Honduran Constitution. While such an accusation is troubling, military coups cannot be condoned, particularly when Honduras' Constitution contains provisions to handle such concerns—impeachment, for one.

The sooner the Honduran military reverses course and allows President Zelaya to return the better it will be for Honduras and all of Central America. He has pledged to leave office at the end of his term, unlike other Latin American leaders who seem to believe constitutions are to be amended with the stroke of a pen so they can remain in office. When President Zelaya returns, if there is credible evidence that he broke laws, he should be held accountable in accordance with the laws of the country.

While I condemn the actions of the Honduran military, I applaud the efforts of the Organization of American States, with the support of the Obama administration, to defuse this situation diplomatically. Removing Honduras' membership and beginning to impose sanctions in concert with widespread international condemnation is the appropriate response.

We should also recognize that the people of Honduras appear to be deeply divided over President Zelaya. Rural Hondurans in particular have been dissatisfied with his performance as President. When he returns to office I hope he reconsiders his priorities and focuses his efforts on improving the lives of the people of Honduras who are most in need of the government's assistance.

HOSPITAL QUALITY REPORT CARD ACT

Mr. JOHANNS. Mr. President, I wish to speak to the Department of Veterans Affairs Hospital Quality Report Card Act of 2009.

One of my proudest jobs in the Senate is serving on the Senate Committee on Veterans' Affairs. Among its other roles, this committee provides oversight of VA health facilities, working with information from the VA, its Inspector General, Veterans Service Organizations, and the general public. We work with a lot of information—it is, after all, our committee's job. But sifting through a pile of reports to find the best hospitals should not be a full time job for those who need health care. This bill will help ensure that it is not.

Not later than 18 months after the date of enactment of this bill, the VA would be mandated to establish a Hospital Quality Report Card Initiative. Under the Initiative, the Secretary would be required to publish reports on the VA's hospitals which assess health care effectiveness, safety, timeliness, efficiency, patient-centeredness, satisfaction of patients and health professionals, and care equity. These factors would be assessed as letter grades, to ensure that the results of these reports are not swabbed over with bureaucratic jargon.

In collecting and reporting this data, the Secretary would have to include extensive and detailed patient-centered information such as staffing levels of nurses, rates of infections contracted at VA hospitals, volume of various procedures performed, hospital sanctions and other violations, the availability of emergency rooms, the quality of care in various hospital settings, and additional measures determined appropriate by the VA Secretary. Each report submitted under the Initiative would have to be available in electronic and hard copy formats, in an understandable manner, and allow for a comparison of the individual VA hospital quality with local or regional hospitals.

The bill would further mandate that the Secretary institute quality control measures to identify potential data irregularities that would lead to artificial improvements in the hospital's quality measurements. In addition, the Secretary would need to evaluate and periodically report to Congress—and the public—on the effectiveness of this Initiative.

I believe that our veterans should easily be able to identify the best hospitals around them. It is unconscionable to make often elderly and disabled veterans wade through pages of statistical data in order to assure themselves that their local VA health facility is providing the best care possible. Often, the factors veterans care about such as the wait times for appointments and medical attention—are not measured reliably or presented to veterans in an accessible or usable fashion. I want to change that. Information on health facilities should not be a privilege; it should be an obligation for the Department of Veterans Affairs. This legislation is a positive step in the right direction.

I encourage my colleagues to cosponsor this commonsense legislation.

COMMENDING ARNOLD PALMER

Mr. CASEY. Mr. President, today, I honor one of the great sports legends of all time, Arnold Palmer. Not only is Arnold Palmer a world-class athlete, he is a generous philanthropist and devoted husband, father, and grandfather. This son of Latrobe, PA, changed the game of golf, both how it is played and how it is appreciated, forever.

Mr. Palmer learned how to play golf when he was merely 4 years old, playing with clubs his father had cut down for him at Latrobe Country Club. His talent emerged visibly at an early age, and he was soon able to outplay children far older than him. He began to caddy when he was 11 years old and later held almost every job at the country club. In his late teens, he also served as a member of the U.S. Coast Guard.

His seven major career victories make Mr. Palmer one of the greatest golfers of all time. He won the Masters Tournament four times in 1958, 1960,